Amherst Health Department / Environmental Health Services
Bangs Community Center, 2nd Fl
70 Boltwood Walk
Amherst, MA 01002
Phone: 256-4033 Fax: 256-4053

PRACTITIONER OF THERAPEUTIC MASSAGE APPLICATION FOR LICENSE

Personal Information: Date:_____

Name:_____Residence:_____
(number & street)

_____
City/Town State Zip Code

Date of Birth:___/___/___ SS# or FedID#_____ Home Tel. #_____
M D Y

Business Information:

DBA:_____
(Either a business name or your own personal name)

Address:_____ Business Phone:_____
(Place of practice)

Name and Address of school attended:_____

Date of Graduation:_____ Hours of Training: _____

Do you have/had a massage license in any other jurisdiction? ___Yes ___No

If yes, list city/towns/states:_____

Was it ever suspended or revoked? ____No ____Yes; explain_____

Are you AMTA certified? ____No ____Yes; Member Number _____
Are you ABMP certified? ____No ____Yes; Member Number _____

If no, give name, address and policy number for personal liability and malpractice insurance.

_____

_____

Signature:_____ Date: _____

FEE: $100.00 annually Original Application ___ Renewal ___